MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Pharmacy

May 2006 • Bulletin 630

Contents

Universal Product Number Pilot Project for Medical Supply Billing

The following notice is in preparation for future changes related to medical supply billing. Please continue to bill for medical supplies according to existing policies until further notice.

The Health Insurance Portability and Accountability Act (HIPAA) mandates the use of HCPCS Level II codes on electronic claims. As a result, the California Department of Health Services (CDHS) plans to discontinue all interim medical supply codes and convert to HCPCS Level II codes. Due to the generic nature of the HCPCS level II codes, CDHS will continue to require attachments on a majority of these claims since the additional information is necessary for claims pricing and payment. This change is anticipated for dates of service on or after January 1, 2008.

Concurrently with the adoption of HCPCS Level II codes, CDHS will begin a two-year pilot program that will give providers the ability to bill using the Universal Product Numbers (UPN), or bar codes. The UPN is a unique product identifier that allows CDHS to process medical supply claims without claim attachments. This allows for more efficient and timely claims payment.

The pilot program, an exception to the HIPAA standards, was granted by the Centers for Medicare and Medicaid Services. The pilot program allows participating providers to submit the UPN on electronic and paper claims for the following four product categories:

1. Urinary catheters and bags
2. Incontinence supplies
3. Ostomy care products
4. Wound care products

CDHS will seek volunteers to participate in the UPN pilot project. When billing through the pilot program for products in the four categories, some of the advantages include:

- On-line real-time claims processing, which allows for immediate claim status notification
- No requirement to submit claim attachments
- Improved speed and accuracy of claim payments

Providers who elect not to participate in the UPN pilot project will bill HCPCS Level II codes on all medical supply claims. The majority of these claims will continue to require attachments, and on-line real time claims processing will not be available.

CDHS will conduct a survey beginning in June 2006 to assess the level of provider interest in the UPN pilot project. Additional details about the project and information about responding to the survey will be on the Medi-Cal Web site and in future *Medi-Cal Updates*.

Please see **Pilot Project**, *page 2*

Pilot Project *(continued)*

Public Comment Forum Available Through July 31, 2006

Providers can e-mail questions and comments regarding the UPN pilot project and medical supply HIPAA compliance efforts to CDHS through the Medi-Cal Public Comment Forum. The "Medi-Cal Comment Forum" page is located in the "HIPAA Update" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**). Providers should click the "HIPAA" link on the home page and then the "Medi-Cal Comment Forum" link. The forum will be available through July 31, 2006. Please note there will be no direct acknowledgement to questions and comments received through the Medi-Cal Comment Forum. However, responses to questions and comments that are relevant to the Medi-Cal community will be summarized into an FAQ and posted on the Medi-Cal Web site this summer.

Osteogenesis Stimulator Documentation Requirements Change

Effective for dates of service on or after June 1, 2006, claims for more than one electrical osteogenesis stimulator device (HCPCS code E0747) for the same recipient no longer require documentation of multiple fractures. Since a TAR is always required when billing for E0747, an approved TAR is sufficient documentation of medical necessity.

This information is reflected on manual replacement page dura bil dme 12 (Part 2).

Increased Reimbursement for DME Repair

Effective for dates of service on or after June 1, 2006, the reimbursement rate for HCPCS code E1340 (repair or non-routine service for durable medical equipment [DME] requiring the skill of a technician, labor component, per 15 minutes) will be increased from $8.75 to $16.47. The hourly reimbursement rate is $65.88.

This information is reflected on manual replacement pages dura 9 (Part 2) and dura cd 24 (Part 2).

DME Policy Changes Retroactive to November 1, 2004

The following Durable Medical Equipment (DME) policy changes are retroactive for dates of service on or after November 1, 2004:

Purchase Frequency limitations

Code	Limitation
A4606	2 per month
E0154	2 in 3 years
E0600	2 in 12 months
E0986	2 in 12 months
E1009	2 in 3 years
E1010	1 in 3 years
E1028	6 in 3 years

For codes K0074, K0075 and K0076 (wheelchair caster tires), up to four (4) tires may be reimbursed on the same date of service when prior authorized for appropriate wheelchairs.

Note: Providers are reminded that the published frequency limit for a specific time period may be exceeded with an approved TAR, but the additional quantity must be billed on a separate claim for a different date of service.

Please see **DME Policy Changes**, *page 3*

DME Policy Changes *(continued)*

Wheelchair Combinations
Based on Medicare DMERC directives, manual wheelchair accessory component codes E0967, E0981, E0982, E0995, E2205 – E2206, K0015, K0017 – K0019, K0042 – K0047, K0050, K0052, K0066 – K0072, K0074 – K0078 and K0452 are not separately reimbursable with manual wheelchair base codes E1161, E1229, E123 – E1238, K0001 – K0007 or K0009.

Additionally, wheelchair accessory component codes E0971, E0981, E0995, E2366 – E2370, K0015, K0017 – K0019, K0042 – K0047, K0050 – K0052, K0090 – K0092, K0084, K0094 – K0096, K0098, K0099, and K0452 are not separately reimbursable with power wheelchair base codes E1239, K0010 – K0012, or K0014.

Reminder: Providers must supply and bill for the specific wheelchair, including both the manufacturer and model, approved by the Field Office on the TAR/SAR.

DME Replacement Items
Claims for DME replacement items that are separately reimbursable with patient-owned equipment must include documentation identifying either the appropriate HCPCS code or a description of the specific DME item and that the item is patient-owned. This documentation is also required if billing with a miscellaneous code (for example, A9900).

Patient lift, bathroom or toilet
The purchase reimbursement for code E0625 (patient lift, bathroom or toilet) is determined using current "By Report" methodology. This item may not be rented.

Humidifier Code Updates
Codes S8182 and S8183 (heated humidifiers) were terminated for dates of service on or after November 1, 2005. Providers may bill for these items using code E1399. Also, humidifier code E0555 is not separately reimbursable with the rental of any respiratory equipment.

Air Power Source Compressor Code Update
Effective for dates of service on or after June 1, 2006, code E0565 will be activated to bill for air power source compressors. Code E0565 may be billed as a purchase with modifier -NU or rental with modifier -RR, and requires prior authorization. The purchase frequency is limited to one in three years.

Pneumatic Compressors and Appliances
Providers are reminded that reimbursement for HCPCS codes E0650, E0651, E0665 and E0668 is restricted to mastectomy patients only. Claims must be billed with ICD-9 code 457.0.

Used Equipment
Medi-Cal does not purchase used equipment. New equipment rented on a trial basis by a patient may be purchased for that patient. The accumulated rental payments will be deducted from the new equipment purchase price.

External infusion pump replacement batteries
Claims for codes A4632 and K0601 – K0605 that were inappropriately denied for a quantity greater than one will be automatically reprocessed.

Wheelchair detachable armrest
Claims for code E0973 that were inappropriately denied as a non-benefit for dates of service between November 1, 2004 and April 1, 2005 will be automatically reprocessed.

This updated information is reflected on manual replacement pages dura 10 (Part 2), dura bil dme 8 and 18 (Part 2), dura bil oxy 8 and 9 (Part 2), dura cd 8, 9, 14, 15, 17, 19 and 22 (Part 2) and dura cd fre 1 and 2 (Part 2).

Ambu-Bag Billing Clarification

Providers are reminded to use HCPCS code A9900 (miscellaneous DME supplies) when billing for ambu-bags. Additionally, when billing for an ambu-bag with A9900, it is no longer necessary to document "patient-owned."

Methylphenidate HCL Correction

An update to Methylphenidate HCL was incorrectly published in the April 2006 *Medi-Cal Update* 629. The changes to Methylphenidate HCL, indicated with a May 1, 2006 effective date, were intended for Dexmethlyphenidate HCL. The provider manual section *Drugs: Contract Drugs List Part 1 – Prescription Drugs (E through M)*, page 49, is updated with the correct information.

Providers Receiving RAD Messages for Over-One-Year Claims

Effective May 1, 2006, providers will no longer receive acknowledgement, approval or denial letters for claims submitted more than 12 months from the month of service and that meet established late submission requirements. Such claims will be noted on a *Remittance Advice Details* (RAD) with a message indicating the status of the claim.

The policy described above applies only to original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining recipient eligibility, reversal of decisions on appealed *Treatment Authorization Requests* (TARs), Medicare/Other Health Coverage delays or other circumstances beyond the provider's control, and were subsequently sent to EDS' Over-One-Year Unit.

This updated information is reflected on manual replacement pages hcfa sub 3 (Part 2) and pcf30-1 sub 2 (Part 2).

New Blood Factor Billing Method for Pharmacy Providers Coming Soon

Effective for dates of service on or after July 1, 2006, pharmacy providers must bill Blood Factor and Anti-Hemophilia Factor products using National Drug Codes instead of billing "By Report." Providers can submit claims hard copy or electronically. However, providers who bill for California Children's Services (CCS) program-only, CCS/Healthy Families, Genetically Handicapped Persons Program (GHPP)-only eligible recipients, or for Medi-Cal/CCS/GHPP-eligible recipients with a CCS or GHPP Legacy or a CCS Service Authorization Request, must continue to bill hard copy with the required authorization by the Children's Medical Services Branch.

All other provider types must continue to bill using the "By Report" methodology currently in place using the *HCFA 1500* claim form.

Medi-Cal will continue to reimburse providers the lesser of the manufacturer's Average Selling Price plus 20 percent or the provider's usual and customary charge.

Provider manual pages regarding this policy will be updated in a future *Medi-Cal Update*.

CCS Service Code Groupings Update

Effective for dates of service on or after July 1, 2006, numerous codes have been end-dated within the California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02 and 07. These end-dated codes appear in bold with a strike through the entire code.

In addition, retroactive for dates of service on or after July 1, 2004, codes have been added to SCGs 01, 02 and 05. These codes are bold and underlined.

It is important to note that on these manual pages SCG 02 includes all the codes in SCG 01; SCG 03 includes all codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01, 02 and 03. These same "rules" apply to end-dated codes.

This information is reflected on manual replacement pages cal child ser 1, 5, 6, 11 thru 18 and 21 (Part 2).

Instructions for Manual Replacement Pages — Part 2

May 2006

Pharmacy Bulletin 630

Remove and replace:
cal child ser 1/2, 5/6, 11 thru 18, 21/22
drugs cdl p1b 49/50
dura 9/10
dura bil dme 7/8, 11/12, 17/18
dura bil oxy 7 thru 10
dura cd 7 thru 10, 13 thru 24
dura cd fre 1/2
hcfa sub 3 thru 6
pcf 30-1 sub 1 thru 5